

A Commitment to Ethical Practice



College publications contain practice parameters and standards which should be considered by all Ontario Respiratory Therapists in the care of their clients and in the practice of the profession. College publications are developed in consultation with professional practice leaders and describe current professional expectations. It is important to note that these College publications may be used by the College or other bodies in determining whether appropriate standards of practice and professional responsibilities have been maintained.

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table of contents

Main section	
Introduction	3
How this guideline for ethical practice was developed	4
Acknowledgement	4
Ethical Values Underpinning Practice	5
Guiding Principles for Ethical Professional Practice	6
Case Scenarios – Applying the Principles to Practice	7
Abuse of Patient/Clients	8
Capable Patient/Client Refusing Plan of Care	9
Changing Individual Scope of Practice	10
Conflict of Interest	11
Consent & Capacity to Consent	12
Disclosure of Critical Incidents	13
Duty to Care	14
End of Life Decision Making	16
Ending the RT-Patient/Client Relationship	17
Evidence-Based Medicine	18
Interprofessional Collaboration	19
Maintaining Professional Boundaries	20
Providing Culturally Competent Care	22
Resource Allocation	24
Substitute Decision Maker	25
Transfer of Accountability	26
Steps to Ethical Decision Making	27
Glossary	28
References	31

INTRODUCTION

Ethical decisions arise for **Respiratory Therapists** (RT) regularly in daily practice – from simply the choice to see one client before another or to disclose a personal story for the sake of building rapport, to more significant decisions such as discussing with a family the risks and benefits of continuing mechanical ventilation or not.

It is not possible for the **College of Respiratory Therapists of Ontario** (CRTO) or the RT's employer to provide specific guidance for each scenario that a practitioner may encounter. Therefore, it is essential an RT practice within an **ethical framework** that will help guide decision-making when providing care. The CRTO's **A Commitment to Ethical Practice** is a first building block among a series of guidance and support documents aimed at helping practitioners deliberate on the choices that face them and discern the best option available.

A Commitment to Ethical Practice is to be used in conjunction with the *Regulated Health Professions Act* (RHPA), the *Respiratory Therapy Act* (RTA) as well as CRTO Professional Practice Guidelines, Position Statements and Policies. Together, these documents provide a framework for achieving safe, effective and ethical Respiratory Therapy practice. They also provide a reference against which to consider any complaints about the practice of any College Member.

Note that words and phrases denoted by **bold** lettering can be cross-referenced in the Glossary at the end of the document.

HOW THIS GUIDELINE FOR ETHICAL PRACTICE WAS DEVELOPED

The “code of ethics” for the practice of Respiratory Therapy was originally interwoven with the CRTC **Standards of Practice** document, which was first drafted in 1996 and revised in 2004. In 2010, a working group of RTs from various practice settings across the province gathered to revise the Standards of Practice document. At that time, it was decided that it was necessary to create a distinct document for ethical RT practice. The group also met with a Medical Ethicist to ensure that the content of this document was consistent with current literature and generally accepted principles and practices. A draft was circulated to the Membership and other key stakeholders in June of 2010. Review of the drafts and final documents was done by the CRTC Patient Relations, Quality Assurance and Registration Committees. Final approval was given by the College Council in September 2010.

This guideline will be reviewed regularly and revised every 5 years at a minimum or as required.

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**In fond memory of Gary Tang RRT.
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ETHICAL VALUES UNDERPINNING PRACTICE

While seldom contemplated explicitly, there are ranges of values that are commonly considered to uphold the practice of healthcare. Values are the most fundamental, non-material things we think of as ‘good’ in our lives, and particularly our interaction with each other – things such as honesty, courtesy, respect, compassion, and **accountability**. Many of these values would be seen as underpinning civil society in general – like honesty, courtesy and respect. Others among them are particularly **relevant** to professional practice – such as compassion and accountability. Most healthcare organizations have an explicit list of values considered most salient for them. Given the lengthy list of values that might be considered relevant, the CRTO has chosen not to specify any particular combination.

To make decisions about ethical care in daily practice, Respiratory Therapists need to be aware of their own values. Specifically, how these values may either align with or sometimes conflict with each other, or with the values of the **patient/client** and/or the members of their healthcare team. This awareness is essential to managing the moral distress that arises when values conflict at a fundamental level – often without being explicitly expressed. Such conflict can trigger distress within us, or a sense of threat between people. This usually has the effect of raising tension and moral distress. If not attended to, the tension can erode the trust at the heart of therapeutic relationships and moral distress can become moral ‘residue’. This residue can linger as a sense of unease and affront for long periods after the situation has somehow been resolved.

Values are such fundamental notions that they do not offer much precision in guiding practice. In order to attend appropriately to values in day-to-day practice, we need to turn them into something more usefully substantive. Principles are general guides for decision-making and action. They are not precise guides, as rules might be, but rather they leave room for **judgement** based on the specific case at hand. They embody one or more of the values that inform them, but work more usefully to keep the values explicit in our decision-making.

GUIDING PRINCIPLES FOR ETHICAL PROFESSIONAL PRACTICE

In order to shape our practice to promote the values we consider ‘good’ in the world, principles offer a first step in application of those values. The principles expressed here are considered equally weighted, binding obligations on practitioners. However, it is also expected that they, at times will directly conflict with each other. When such conflict arises, the task becomes determining which principle should overrule the other. In these situations, an awareness of the principles and how they relate to each other and the values they promote is essential.

The Four Principles (Beauchamp, 2008)

1. **Respect for Autonomy – respect for free will**

Autonomy refers to the capacity to think, decide and act on one's own free initiative and it is the ultimate right of all individuals. Respiratory Therapists therefore should do whatever is their power to assist the patient/client to come to their own decision. The RT should consult with their patients/ clients and obtain their agreement (consent) before doing things to them.^(Gillon, 1994) This requires effective communication which in turn entails both listening and providing the patient/client with the necessary information. Respecting an individual's autonomy requires that a competent individual's right to ultimately determine his/her plan of care is honoured, even if that plan differs from that of the **healthcare team**.

2. **Beneficence – to do good**

Beneficence is the obligation that healthcare professionals have to act in a way that is of benefit to those for whom they care. The Respiratory Therapist's vocation, like all vocations in healthcare, is fundamentally concerned with providing services to promote and maintain well-being. Where this may not be possible, the RT's services are concerned with appropriate support through a dying process. In addition to the services themselves, the manner in which services are delivered can be more or less ‘beneficent’ – that is, they can demonstrate sensitivity, empathy, collegiality and other ‘goods’ beyond those of the ‘clinical outcome’.

3. **Non-malefeasance – avoid doing harm**

As most treatments involve some degree of risk or have side-effects, it is important to weigh the risk and benefits of a proposed plan of care. The principle of non- malefeasance requires that an RT consider the possible harm that any intervention might do. Non-malefeasance and beneficence can sometimes come into direct conflict with each other. For examples, it may be seen as beneficial to sustain someone's life through continuing ventilation or other therapy, but it may simultaneously require the individual to experience continuing pain or discomfort.

The Four Principles (continued)

4. Distribute Resources with Justice – act fairly

In allocating care, the justice principle holds that patient/clients in similar situations should have access to the same care, and that in allocating resources to one group we should assess the impact of this choice on others. The application of distributive justice is required when resources are limited and priorities must be set and care triaged based on need.

CASE SCENARIOS – APPLYING THE PRINCIPLES TO PRACTICE

The following case examples are used to illustrate how the principles are applied in decision making and behaviour in practice. Each case is explored with reference to the principles, but also with brief discussion of the values underpinning those principles.

RTs are encouraged to use the Steps to Ethical Decision Making algorithm located on page 27 to work through these examples.

The algorithm may also prove useful for determining the best possible course of action when confronted with ethical issues that arise as part of a RTs practice. This can be used in conjunction with their organization’s established ethical decision-making processes (e.g., Staff Ethicist, Medical Ethics Committee, etc).



Abuse of Patients/Clients

Any abuse of a patient/client is unacceptable and includes, but is not limited to such forms of abuse such as: emotional/verbal; physical; sexual and financial. It also includes neglect and insensitivity to religious and cultural beliefs. The CRTO is committed to the prevention of all types of abuse that might occur within the RT-patient/client **therapeutic relationship**.

A RT is called to perform an arterial blood gas puncture on a patient/client in the emergency department. The patient/client is verbally abusive to the RT and refuses to hold his arms still. The RT restrains the patient/clients by securing his hands to the bedrails. Would this be considered to be physical abuse and what other options were available?

The ethical dilemma revolves around respecting the patient/client's free will, which conflicts with the RT's need to do good and avoid doing harm.

Most hospitals have organizational policies regarding patient/client restraints and those must be taken into consideration when choosing a course of action. The first choice lies in either doing the blood gas or not, and so the issue of how important it is to have these results needs to be explored. If they are considered to be vital to the patient/client's care, then the choice may become to sedate the individual or physically restrain him. One of the risks of restraining him is that it could be considered to be physical abuse because the patient/client has not consented to either the procedure or to being restrained.

Generally, healthcare providers cannot use any form of restraint without the patient/ client's consent, except in an emergency situation in which there is a serious threat of harm to the individual or others, and all other measures have been unsuccessful. The RT should refer to their organization's policies on the use of restraints.

For more information, please see the CRTO Prevention of Abuse of Patient/clients Professional Practice Guidelines (PPG) at: <http://www.crto.on.ca/pdf/PPG/abuse.pdf>.

Capable Patient/Client Refusing Plan of Care

Patients/ clients are considered **capable** unless proven otherwise. They have the right to refuse any treatment/ procedure being proposed and to revoke any consent previously given to any or all aspects of their plan of care. Sometimes their decisions are not what the healthcare team has determined to be the best course of action. However, the patient/client's wishes must be must be respected; unless the practitioner has reasonable grounds to determine that patient/client lacks the requisite capacity to consent.

An oxygen discharge assessment is performed and the RT informs a patient/client that she has qualified for home oxygen, which has been clinically proven to be beneficial for the individual's medical condition. However, the patient/client states that she does not need it and refuses the referral for home oxygen. How should the RT proceed?

The ethical principles involved in this scenario include respect for the patient/client's free will which is in conflict with the RTs need to do good.

The RT must ensure that the patient/client is fully informed of the risks of her decision but ultimately must respect the capable patient/client's decision. The ordering physician needs to be informed of the individual's decision as well as any other affected parties (e.g., patient/clients nurse). In addition, the conversation with the patient/client should be carefully documented.

For more information on consent and the capacity to consent, please see the CRTO Responsibilities Under Consent Legislation PPG at:
<http://www.crto.on.ca/pdf/PPG/UnderConsent.pdf>

Changing Individual Scope of Practice

The area of practice that an RT regularly works in is considered his/ her “individual scope of practice”. It is essential that each RT ensure they are clinically competent to perform his/her duties within this scope safely and effectively. Advances in medicine and changing roles within the workplace require RTs to continually upgrade their knowledge and clinical skills. For example, the acuity level of patients/clients in the hospital setting is rising and this is creating a need for more advance levels of expertise in emergency and critical care. Moreover, all of this is occurring within the framework of increasing pressure for healthcare organizations to be as cost effective as possible. This makes it essential for Respiratory Therapists to not only embrace the on-going evolution of their own practice but to actively take a leadership role in promoting change within the profession as a whole.

A RT who has worked for a number of years exclusively in a diagnostic lab setting is being told by his employer that he will be required to begin taking some shifts in the ICU. Whose responsibility is it to ensure that the RT is competent to assume this added responsibility?

The ethical principles involved include the practitioner’s need to do good and to avoid doing harm.

There is a shared accountability between the employer and the RT to ensure competency. The employer needs to do whatever is in their power to facilitate the RT obtaining and maintaining the necessary competencies. However, it is ultimately the RT’s responsibility to be competent to perform whatever tasks are required of him/ her.

For more information, please see the CRYPTO Position Statement on Scope of Practice & Maintenance of Competency at: <http://crto.on.ca/pdf/Positions/SOP.pdf>

Conflict of Interest

The CRTO **Conflict of Interest** Professional Practice Guideline (PPG) states that a conflict of interest is created when an RT puts themselves in a position where a reasonable person could conclude that he/she is:

- undertaking an activity or
- having a relationship

that effects or influences his/her professional judgment. A conflict of interest may be actual or apparent (perceived).^(CRTO, 2005) A good rule of thumb is that if an RT senses that he/she may be in a conflict of interest, he/she likely is.

An RT working in the home care setting visits one of her patients/clients on a regular basis to change the individual's tracheostomy tube. As a result of this frequent interaction, they develop a congenial but purely professional relationship. The patient/client passes away after a few years and leaves the RT a large sum of money in his will. The RT was not aware of this fact until after the patient/client's death and at no point did she encourage the patient/client to alter his will. Would it be a conflict of interest for the RT to accept the money?

The ethical principle involved is to act fairly.

In this scenario, there may not be an actual conflict, as the RT's care of the patient/client was not likely to have been affected by this financial gift. However, there is a possibility of a perceived conflict of interest and therefore the RT should not accept the money.

For more information, please see the CRTO Conflict of Interest PPG at:

http://www.crto.on.ca/pdf/PPG/conflict_of_interest.pdf.

Consent & Capacity to Consent

The *Health Care Consent Act* (HCCA) states consent may be implied or expressed and a patient/client can revoke his/ her previously expressed consent to treatment at anytime. Consent must be informed, which means that information relating to the treatment has to be received and understood by the individual. (HCCA, 1996)

Treatment can occur without the individual's consent only in specific circumstances, such as an emergency. However, reasonable steps must be taken to obtain consent prior to the emergency and no reason(s) should exist for the healthcare team to believe that the patient/client would have not wanted the treatment.

A patient/client with severe ischemic cardiomyopathy initially states that he wants life saving measures performed should he deteriorate, and currently has a "full code" status. Just prior to his full cardiac arrest, however, he clearly tells the RT (who is alone in the room with him) that he does not wish to be resuscitated. He states that he understands that he will likely die from his disease and was "just going along with what his wife wanted." The wife enters the room just as the code is called and she wants "everything done." What should the RT have done, both at the time the patient/client disclosed this information and after the code was called?

The ethical principle involved is primarily the respect for the patient/client's free will which must be balanced with the need to do good and do no harm.

The RT is required to honor the patient/client's most recently stated wishes. The patient/client's wishes need to be articulated to the attending healthcare team and the RT should, if at all possible, refrain from participating in any resuscitation efforts. The CROTO Responsibilities under Consent Legislation PPG outlines what steps can be taken if the patient/client's expressed wishes are contrary to the family's and/or the healthcare team's plan of care. Prompt and open communication with all affected parties is essential, as is clear and objective documentation.

For more information, please see the CROTO Responsibilities under Consent Legislation PPG at:

<http://www.crto.on.ca/pdf/PPG/UnderConsent.pdf>

Disclosure of Critical Incidents

Each RT has an ethical, professional and legal responsibility to provide full and frank disclosure of all **critical incidents** (adverse event) as soon as is reasonably possible. In addition, recent amendments to the *Hospital Management* regulation made under the *Public Hospitals Act* now requires healthcare administrators (e.g., hospital administration) to establish a system for ensuring prompt disclosure of every critical incident to all affected parties. (O.Reg.423/07, 2007)

It is important to note that it is not considered a critical incident if the event came about not from negligence or sub-standard medical care but as a result of the patient/client's underlying medical condition. This requirement for disclosure also does not apply to errors that do not harm the patient/client (**near misses**).

An RT on nights is called stat to attend to an infant whose ETT has become separated from the 15mm connector. The tube had migrated into the infant's airway and the RT had to use Magill forceps to retrieve it. The infant experiences minimal bleeding and a brief period of de-saturation. It was apparent that the RT on days had not secured the ETT properly and this had likely led to the disconnection being obscured until it was too late. Is this a critical incident and what should the RT do regarding the co-worker's error?

The ethical principles involved are to do good and do no harm.

The incident outlined in the scenario would likely be determined to be a near miss as the infant was fortunately not significantly harmed. Therefore, disclosure to the patient/client's family may not be required. However, the RT should follow her hospital's established incident reporting processes. It is also important that the issue of improper taping of the ETT be addressed, as it may have led at least in part to the dislodging.

The *Apology Act* seeks to enable healthcare professionals to make an **apology** that cannot be taken into account in any determination of fault or liability in connection with that matter.

(Apology Act, 2009) More information on this act can be found at:

http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_09a03_e.htm.

Duty to Care

For the purpose of this document, “duty to care” is viewed from primarily an ethical, rather than legal perspective. The Ontario Health Plan for an Influenza Pandemic states that a healthcare worker has “an ethical duty to provide care and respond to suffering.” (OHPIP, 2008) The University of Toronto Joint Centre for Bioethics 2005 paper Stand on Guard for Thee reiterates the ethical duty to care that healthcare professionals owe the public. (Joint Centre for Bioethics, 2005) However, both documents do allow that duty to care is contextual and a great many factors can affect a practitioner’s ability to provide optimal patient/client care.

During a pandemic influenza outbreak, several private day care centers close. A RT who works in the emergency department at a large teaching hospital is the single parent of a child who attends one of these day care facilities. The hospital is experiencing a significant increase in visits to the emergency department and several of the hospital’s staff RTs are already off sick. What is the best course of action for this particular RT?

The ethical principles are to act fairly, do good and do no harm.

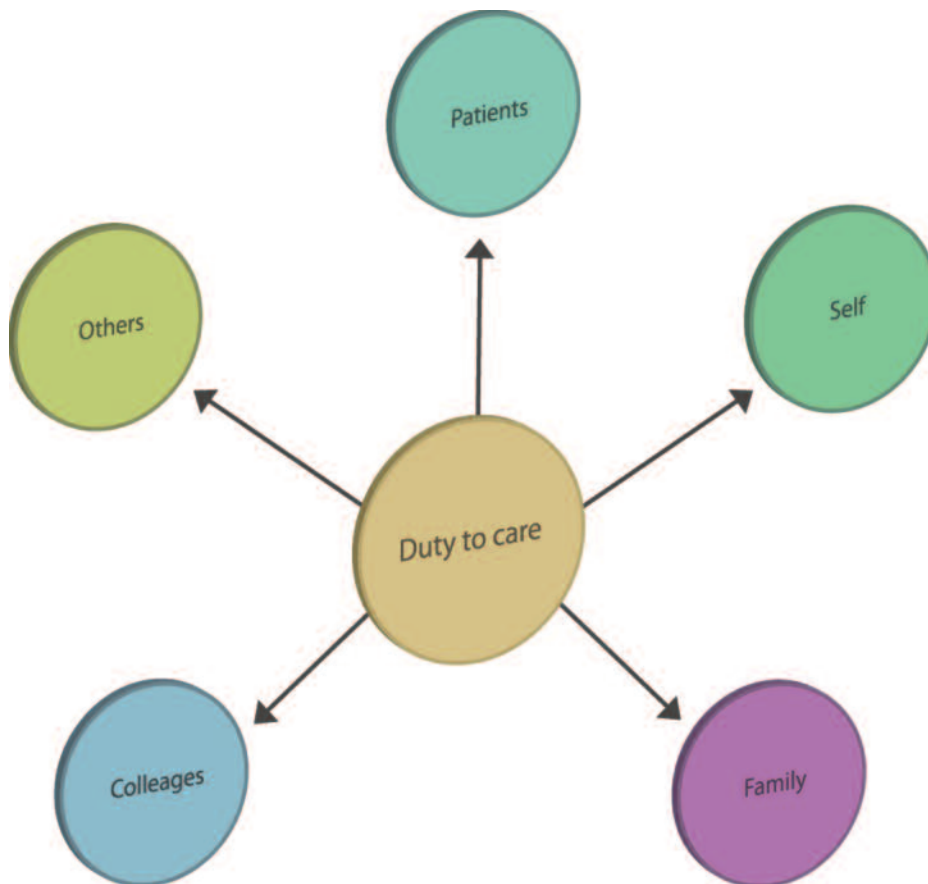
In this circumstance, the RT is required to balance the needs of her patients/clients with the needs of her child. It is not clear that patient/client care would suffer if she did not come into work (e.g., there is other staff who can provide the same care). In addition, if she was unable to make other babysitting arrangements, she would not legally or morally be able to leave her child unattended. Members are encouraged to anticipate and seek to address factors that may interfere with their ability to carry out their professional duties.

These multiple obligations can result in conflicting priorities which are quite specific to each individual. Therefore, each RT must ultimately balance his/her own reality with the best interest of their patient/client. When faced with managing conflicting duties, the expectation of the College is that its Members will, to the very best of their abilities, provide ethical, safe and competent patient/client care. *(continued)*

Duty to Care (continued)

S.43(1) of the Occupational Health & Safety Act (1990) delineates under what circumstance certain types of employees can refuse work due to fear of exposure to a hazard. This act clearly articulates that hospital workers do not have a right of refusal to work if:

- if the hazard is inherent in the work the employee does; or
- when the employee's refusal to work would directly endanger the life, health or safety of another person.¹



¹ Occupational Health & Safety Act. (1990). *Legislative Assembly of Ontario*.

End of Life Decision Making

The legal rights of the patient/client at the end of his/her life are the minimum ethical requirements. Capable individuals have a right to make their own decisions regarding their medical care. If that capability is called into question, they have the right to have their capacity assessed. The HCCA outlines the process that must be followed if a patient/client is deemed incapable, which includes the appointment of a **Substitute Decision Maker (SDM)**. (HCCA, 1996) It is important to note, however, that the final decision as to the plan of care rests with the patient/client or SDM. Not only is consent to treatment required, it is also necessary for “withdrawing” or “withholding” treatment. (HCCA, 1996)

A newborn infant with severe Spinal Muscular Atrophy (SMA) type 1 is requiring continuous NIPPV. Because her prognosis is grave, the physician in charge of her care has determined it to be “everyone’s best interest” to remove her from the BiPAP. However, the parents want this treatment to continue, in the hope that she can eventually go home. The RT has been asked to remove the BiPAP. How should he proceed?

The ethical principles involved are respect for the patient/client’s free-will which is in conflict with the RTs need to do good and do no harm.

The parents in this case are the child’s guardians and therefore are able to make decisions for their child. The healthcare team probably has very valid concerns as to the infant’s long-term survival and the impact that caring for this child at home might have on the family. The team should be open and frank with the parents as to the predicted outcome. If an agreement on the plan of care cannot be obtained and if the healthcare team feels that the parent’s decision is not in the child’s best interest, the case could be presented to the **Consent and Capacity Review Board**. In the interim, however, the parent’s decision stands and the RT should refrain from removing the infant from NIPPV.

For more information, please see the CRTO *Responsibilities under Consent Legislation* PPG at:
<http://www.crto.on.ca/pdf/PPG/UnderConsent.pdf>.

Ending the RT-Patient/client Relationship

Sometimes it is necessary for an RT to end the therapeutic relationship with a patient/client. If the services of the RT are being discontinued because the individual no longer requires them, then it is usually a matter of making sure all of the proper documentation is in place and that the patient/client's primary physician has been informed. If, however, the RT is no longer able to provide care to an individual still in need of services, then it is incumbent upon the respiratory therapist to ensure that care has been transferred to the most appropriate person and/or facility.

A patient/client being cared for by a home oxygen company has been formally warned twice that the oxygen will be removed due to safety concerns (i.e., smoking as well as unsafe handling and storage). On a subsequent visit the RT finds him smoking in his living room with his grandchildren playing nearby. How should the RT proceed?

The ethical principle involved is primarily the respect for free will which must be balanced with the need to do good and do no harm.

Most home care companies have policies and procedures around the removal of oxygen from a patient/client's home. These policies should outline how and when the physician responsible for the individual's care is notified regarding the possible need to remove of the oxygen from the patient/client's home. The physician may provide direction as to how to meet the individual's ongoing oxygen needs and all communication with the physician must be documented. The patient/client should sign the initial explanation of the safety requirements and any subsequent safety violation warnings. Once the RT is satisfied that the requirements under his/her employer's policy have been met, the RT could remove the oxygen equipment and advise the patient/client to seek medical attention, as required, at his local hospital.

It is important to note that if an RT is changing employers (e.g., moving from one home oxygen company to another) they should in no way endeavour to entice a patient/client to change companies as well. The therapist should, consider the best interest of the patient/client over his/her own needs. However, each RT has the right to practice in a safe environment, and the safety of others must be taken into consideration.

Evidence based and reflective practice

To provide care that is of the greatest benefit to the patient/client that RTs serve requires the integration of knowledge that comes from the best and most current available research. Evidence-based medicine challenges the notion that practitioners should continue to adhere to “accepted” medical practices that have no basis to support them.

In order to ensure the application of evidence-based knowledge, it is helpful if the RT is familiar with literature review techniques and is able to utilize the resources at their disposal (e.g., hospital and electronic libraries.) It is also essential that the practitioner regularly reflect on his/her **competency** needs and seek on-going opportunities for professional development.

An internal medicine specialist has ordered an inappropriately high tidal volume (>10 ml/kg) for a patient/client with ARDS and has not written an order to ventilate to ABGs. The hospital has a policy that the National Heart, Lung and Blood Institute (NHLBI) ARDS Mechanical Ventilation Protocol should be implemented for individuals who meet the inclusion criteria. How should the RT proceed?

The ethical principles involved are to do good and do no harm.

First, the RT is required to act in the patient/client’s best interest. If the practitioner has sound reason to question any medical order, then he/she should immediately bring this to the attention of the individual who wrote the order. Sometimes a careful and well-informed explanation on the part of the RT can be enough to have the order changed. If not, then how the RT proceeds will vary depending on how detrimental he/ she feels the existing order will potentially be for the patient/client. In this scenario, if the RT was not satisfied with the outcome of the discussion with the ordering physician, then there is usually another level of administration to take his/her concern (e.g., chief of staff, administrator on-call, etc). In the interim, the patient/client should be set on whatever set of parameter is considered to be safe and everything must be carefully documented. All other staff caring for the patient/client (i.e. bedside nurse), should also be informed.

Interprofessional Collaboration

Interprofessional collaboration (IPC) refers to the positive interaction of two or more healthcare professionals who bring their unique skills and knowledge to assist patients/clients and their families with their health decisions. (EICP, 2005) There exists a large body of research confirming the benefits of IPC for patients/clients, the healthcare professionals and the healthcare system as a whole.

The overall goal of IPC is to optimize patients'/clients' access to the skills and competencies of a wide range of health professionals. In certain circumstances, optimal access to care is best obtained by ensuring that as many practitioners as possible can provide a given service. In other instances, it is in the best interest of patient/client care to ensure that a select group of "experts" provide a specific service.

The ICU nurses at a community hospital have approached their administration (without consultation with the RT dept.) requesting they be permitted to perform arterial line insertion (a task which up until now has been performed only by the RTs). The RTs react by taking their objections (without consultation with the ICU nursing dept.) to administration. What should have been done to ensure a collaborative process and what outcome would be in the best interest of optimal patient care?

The ethical principles involved are to do good and do no harm balanced with the need to act fairly.

Although the process described in the scenario was definitely not a good example of IPC, an argument could be made for either side having a valid argument in the best interest of the patients/clients. In certain practice settings, having the nurses also insert arterial lines would enhance patient/client's access to the procedure. In other situations, having just the RTs do it would ensure that only the most practiced and skilled practitioner performs the procedure. The primary concern must always be what is best to ensure optimal patient/client care, as opposed to "turf expansion or protection".

Maintaining Professional Boundaries

The **therapeutic relationship** between an RT and his/her patient/client is one of empathy, trust and respect. It is important to acknowledge that there exists within this relationship an inherent power imbalance. The RT has access to specialized knowledge, privileged information that the patient/client does not have. The RT also has the ability to advocate on behalf of the patient/client. Therefore, it is essential that RTs respect the relationship they have with their patient/client through effective communication, patient/client centered care and the maintenance of **professional boundaries**.

In a therapeutic relationship with a patient/client, the best interests of that individual always come first, unless doing so would endanger the welfare of others. The patient/client's vulnerability places the obligation on the RT to manage the relationship appropriately. Examples that the RT may be crossing professional boundaries in the RT's therapeutic relationship are:

- Disclosing personal problems to a patient/client;
- Accepting gifts from a patient/client that could potentially change the nature of the relationship and influence the level or nature of care; or
- Spending time outside the therapeutic relationship with a patient/client.

RTs also have **professional relationships** with all other members of the healthcare team with whom they interact with as they carry out their duties. In some of these relationships, a power imbalance mirrors that in the RT's therapeutic relationship (e.g., staff RT supervising Student RTs, Charge Therapist overseeing newer staff RTs). It is essential for the RT to adhere to the same standard for the maintenance of these professional relationships as they do in their therapeutic relationships.

(continued)



Maintaining Professional Boundaries (continued)

An RT who works in a sleep lab is asked out on a date by a patient/client who had been assessed in her lab a week earlier. She accepts and they eventually marry. Has she failed to maintain appropriate professional boundaries?

The ethical principle involved is to act fairly.

Unfortunately, even when acting fairly, one can be perceived as not acting fairly (giving preferential treatment, for example). The RT could have been considered to have violated professional boundaries if the patient/client continued to be cared for at the sleep lab where the RT worked. The only way that a personal relationship would be permissible is if the therapeutic relation had officially ended and this must be clearly documented.

A Registered Respiratory Therapist (RRT), acting in a Clinical Instructor capacity at a teaching hospital, receives a “friend request” on Facebook by a Student RT currently rotating through the hospital. The RRT accepts and they begin an exchange on-line of personal comments and photos. Has the RRT crossed the professional boundaries?

The ethical principle involved is to act fairly.

Because an imbalance of power also exists between the staff therapists and students, the RRT is prohibited from engaging in a personal relationship with this individual. This is most definitely a violation of professional boundaries, regardless of the content of the comments and photos.

Providing Culturally Competent Care

In the healthcare setting, cultural competence refers to the ability to provide appropriate and effective medical care to members of various cultural groups. RTs provide care to patients/clients with diverse values, beliefs and behaviours. A practitioner therefore must become competent in providing equitable care through the process of gaining a congruent set of behaviours and attitudes. This progression begins with an awareness of the how diversity manifests itself and what impact it has on the provision of healthcare. Providing culturally competent care will allow the RT to provide optimal care for all patients/clients and maintain compliance with laws and recommendations.

A male RT attending a delivery is told he is not permitted to be in the delivery room because the mother's cultural beliefs prohibits any man other than her husband and the physician from being present. However, the therapist in question is the only RT available to provide any necessary resuscitative care. Should he disregard the mother's request and attend the delivery in the delivery room?

The ethical principles involved are respect for free will, balanced with the need to do good and do no harm.

Where possible, accommodation should be sought that would honour the mother's wishes, while at the same time ensuring that optimal care is provided to her newborn infant. For example, arrangements could be made to have the resuscitation team ready to receive the infant in an adjoining room immediately after delivery.

8 Steps to Cultural Competence for Healthcare Professionals (IWK Health, 2006)

1. Examine your values, behaviours, beliefs and assumptions.
2. Recognize racism and the behaviours that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with the core cultural elements of the community you serve.
5. Engage patients/ clients to share how their reality is similar to, or different from, what you have learned of their core cultural elements.
6. Learn how other cultures define, name and understand disease and treatment.
7. Develop a relationship of trust with patients/clients and co-workers by interacting with openness, understanding and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse community that you serve.

Ontario Human Rights Code

Ontario's **Human Rights Code** outlines the right of every Ontario resident to receive equal treatment with respect to goods, services and facilities without discrimination based on a number of grounds including race, age, colour, sex, sexual orientation, and disability. Respiratory Therapists are therefore required to comply with this Code when providing care to patients/clients. Broadly this means that services are to be provided equally to all regardless of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status and/ or disability (Ont.

Human Rights Code, 1990).



Resource Allocation

Certain emergencies (e.g., pandemics) as well as financial and human resource constraints make the consideration of how to manage conflicting duties all that more critical for each healthcare professional. Under the extreme pressure that such an event can have on the healthcare system, **surge response strategies** often need to be put into place to ensure that the greatest number of patients/clients benefit from the available resources. In these situations, the basic principles for ethical treatment of patients/clients must remain. However, there sometime needs to be a shift in the focus from what is best for each individual to what will benefit those most in need. Even less urgent situations may necessitate making the best use of limited resources.

A patient/client who has suffered a head injury is being transported from a community hospital to a tertiary care centre. There are 2 RTs on nights at the community hospital and one is being asked to accompany the non-intubated individual on transport. This would leave the other RT to care for the entire hospital alone. What would be the best course of action?

The ethical principles involved are to do good and do no harm, balanced with the need to act fairly.

There are a great many variables when determining whether the RT should go out on the transport or remain in hospital. Many facilities have criteria set out in policy in order to assist the RT in establishing priorities in situation such as this. There is no one correct answer and it depends on factors such as the likelihood the patient/client going on transport will not be able to protect their airway, the level of current acuity at the hospital, etc.

Substitute Decision Maker

The *Healthcare Consent Act* (HCCA) defines capacity as the ability to understand information necessary to make an informed treatment decision, and appreciate the reasonably foreseeable consequences of a decision or lack of a decision (HCCA, 1996). As mentioned previously, if a patient/client is determined to be incapable with respect to his/her medical care, a Substitute Decision Maker (SDM) may give or withhold consent on the individual's behalf. It is important to note, however that the SDM is required to honour the patient/client's wishes, if known to be articulated when he/she was capable. If there are no **known capable wishes**, then the SDM must act in the patient/client's best interest.

A 35 year old woman who is suffering from end-stage MS is admitted to the ICU in severe respiratory distress. She is unable to communicate and her prior wishes are not known to the healthcare team. However, the husband, acting in his capacity as SDM, is demanding that his wife be placed on life support. The RT is called to intubate. Is the SDM acting in the patient/client's "best interest" and how should the RT proceed?

The ethical principles involved are to do good and do no harm balanced with the respect for free will.

For one thing, it is difficult to determine if the husband is acting in his wife's best interest, as we do not know if she had any prior competent wishes, or what they might have been. Her family physician is someone who may know, as hopefully this is a conversation they would have had, knowing the likely course of her disease. Another consideration is whether her current respiratory distress is the result of something that is curable (e.g., pneumonia) or a result of the disease progression. If at all possible, the RT should try to avoid intubation until such time as it can be established that this is the best interest of the patient/client.

Transfer of Accountability (TOA)

Communication of information between healthcare providers is a fundamental component of patient/client care. According to a study done by the U.S. Joint Commission on Accreditation of Healthcare Organizations in 2003, almost 70% of all sentinel events are caused by breakdown in communication.^(Alvarado, K, et al., 2006) It is during the transfer of accountability (sometimes referred to as “transfer of care”) that there is the most significant risk of harm to the patient/client.

It is also the times when breaches in patient/client **confidentiality** frequently occur. Not only can information that should be passed on be missed or misunderstood, but it may also be generally inappropriate, or inappropriate for certain personnel to hear. It is essential when disclosing personal health information to remember who is in the patient/client’s **circle of care**. This term is not defined in the 2004 *Personal Health Information Protection Act*, but has been generally accepted to be the healthcare providers who deliver care and services for the primary therapeutic benefit of the patient/client. It also covers related activities such as laboratory work and professional or case consultation with other healthcare providers².

Some organizations have implemented a standardized, evidence-based approach to TOA in order to improve the effectiveness and coordination of communication. Some hospital departments have utilized a checklist type format (e.g., code status, infection control requirements, risk concerns) to ensure that nothing important is overlooked during “shift change”. The CRTO encourages its Members to evaluate their own TOA processes and perhaps customize tools used within their own facility.

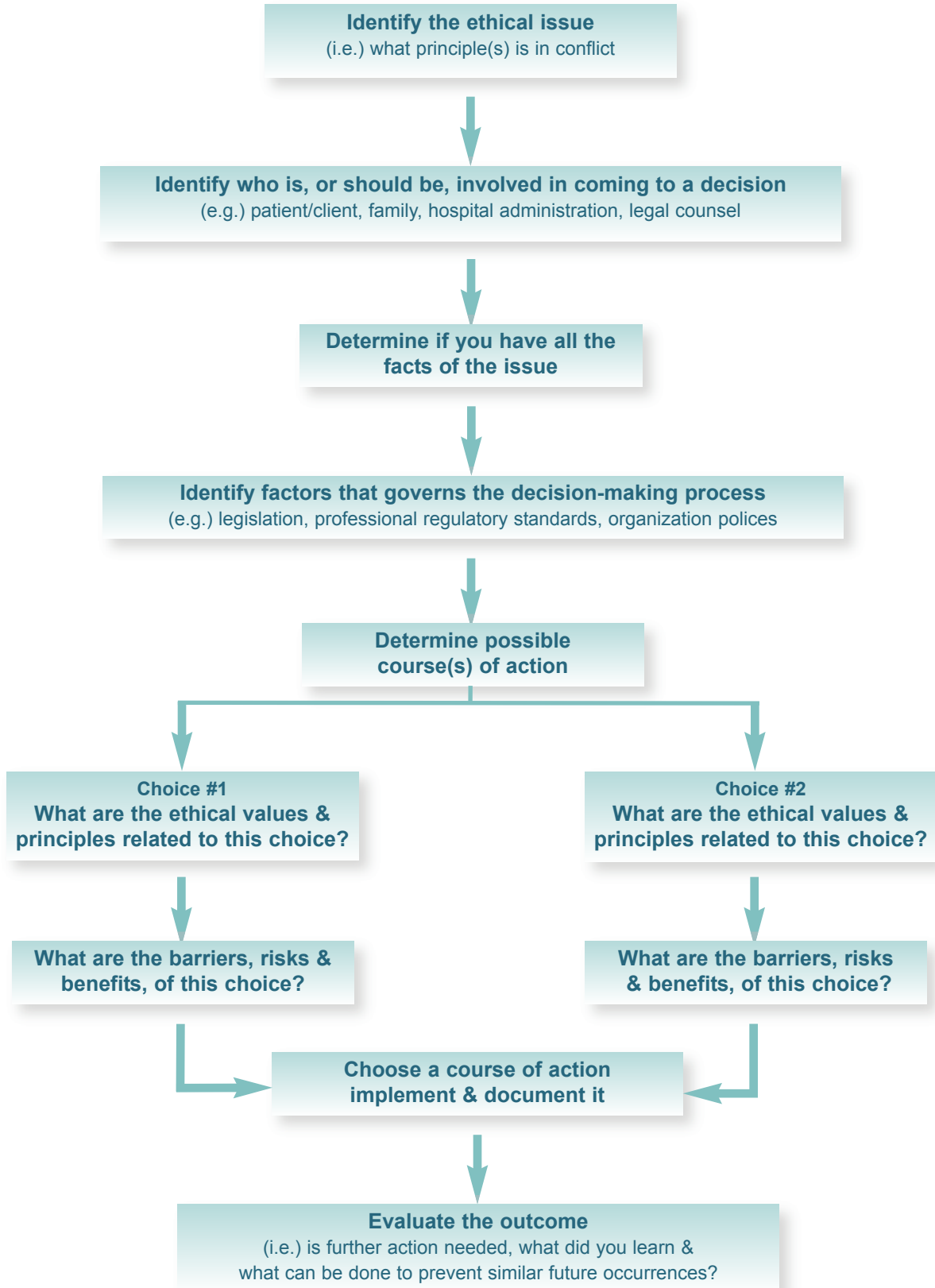
During a verbal report in the staff lounge, an RT reveals to all those present that a patient/client seen in emergency during the previous shift had been brought in following a failed suicide attempt. The door of the lounge is open and nursing staff coming to and from work are passing by in the hallway. In addition, the patient/client is the sister-in-law of the Ultrasound Technician, who happens to be in the staff lounge when report is being given. What ethical values/ principles have been violated and what steps could have been taken to prevent this from happening?

The ethical principles involved are to do good and do no harm.

The RT giving report has shown a lack of respect for the dignity of the patient/client in question. Also, the patient/client’s confidentiality has been violated, as the information was not disclosed in a manner that prevented those outside the individual’s circle of care from being privy to it. Every effort needs to be made to ensure the information shared at handover is accurate, complete and that the risk of inappropriate disclosure of personal health information is minimized.

² Transfer of Accountability: Transforming Shift Handover to Enhance Patient Safety.

Steps to Ethical Decision-Making



GLOSSARY

Accountability	Taking responsibility for decisions and actions, including those undertaken independently and collectively as a member of the healthcare team; accepting the consequences of decisions and actions and acting on the basis of what is in the best interest of the patient/client.
Apology/ Apology Act	An expression of sympathy or regret, a statement that a person is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit fault or imply an admission of fault or liability in connection with the matter to which the words or actions relate. The 2009 Apology Act aims to increase transparent and open communication among health care professionals, patients and the public. (Apology Act, 2009)
Autonomy	Recognizing that a patient/client has the right to accept or reject any Respiratory Therapist and any care recommended or ordered.
Circle of Care	The term "circle of care" is not a defined term under the PHIPA or the federal privacy legislation, the <i>Personal Information and Protection of Electronic Documents Act</i> (PIPEDA). The term emerged in a series of questions and answers developed by Industry Canada called the <i>PIPEDA Awareness Raising Tools (PARTs) Initiative for the Health Sector</i> . There it was defined as follows: <i>The expression includes the individuals and activities related to the care and treatment of a patient/client. Thus, it covers the healthcare providers who deliver care and services for the primary therapeutic benefit of the patient/client and it covers related activities such as laboratory work and professional or case consultation with other healthcare providers.</i>
Competent/ Competency	Having the requisite knowledge, skills and judgement/abilities to perform safely, effectively and ethically and applying that knowledge, skills and judgement/abilities to ensure safe, effective and ethical outcomes for the patient/client.
Confidentiality	In Canada, a healthcare professional owes an ethical and legal duty of confidentiality to his or her patients. However, this right of confidentiality is not absolute. A health information custodian may disclose personal health information if they reasonably believe there is a risk of harm [PHIPA s.40(1)].
Consent & Capacity Review Board (CCRB)	An independent body created by the provincial government of Ontario under the Health Care Consent Act.

GLOSSARY (continued)

<p>Conflict of Interest</p>	<p>A conflict of interest exists where a Respiratory Therapist engages in any private or personal business, undertaking or other activity or has a relationship in which,</p> <ul style="list-style-type: none"> • the Respiratory Therapist’s private or personal interest directly or indirectly conflicts, may conflict or may reasonably be perceived as conflicting with his or her duties or responsibilities as a healthcare professional; and/or • the Respiratory Therapist’s private or personal interest directly or indirectly influences, may influence or may reasonably be perceived as influencing, the exercise of the member’s professional duties or responsibilities. <p>It is important to note that a conflict of interest may be actual or apparent (perceived).</p>
<p>Critical incidents</p>	<p>An unintended event that occurs when a patient/client receives treatment in the hospital that results in death, injury or harm to the patient/client and does not result primarily from the patient/client’s underlying medical condition or from a known risk inherent in providing the treatment. (Ont. Reg. 423/07, 2007)</p>
<p>Ethical/ Ethical Framework</p>	<p>Relating to accepted professional standards of conduct; of or relating to principles of right and wrong in behaviour.</p>
<p>Health Care Consent Act (HCCA)</p>	<p>The HCCA outlines the requirement for healthcare professionals who proposes a treatment or plan of care to ensure that they receive informed consent from the patient/client or his/ her substitute decision maker before proceeding.</p>
<p>Health Information Custodian</p>	<p>Defined in PIHIPA as “a person or organization who has custody of control of personal health information [PHIPA, s.3(1)]. This is generally the employer.</p>
<p>Healthcare Team</p>	<p>Peers, colleagues, and other healthcare professional (regulated and non-regulated).</p>
<p>Human Rights Code</p>	<p>Respiratory Therapists have a responsibility to understand and respect individuals regardless of differences that may include but are not limited to: race; ancestry; place of origin; colour; ethnic origin; citizenship; creed; sex; sexual orientation; age; marital status; family status or disability. (Ont. Human Rights Code, 1990)</p>
<p>Judgement</p>	<p>Judgement is the cognitive process of reaching a decision or making an observation.</p>
<p>Knowledge</p>	<p>Is a body of information applied directly to the performance of a function.</p>
<p>Known Capable Wishes</p>	<p>The <i>Health Care Consent Act</i> (HCCA) refers to “know capable wishes”, which refers to the expressed wishes of a patient/client. This legislation recognizes that any individual, while capable, may express his/ her wishes with respect to treatment decisions that are to be made on his or her behalf in the event that he or she becomes incapable.</p>

GLOSSARY (continued)

Near Misses	These particular occurrences are identified as errors but do not result in harm to the patient/client. Therefore, they may not require disclosure to patients/clients in all cases and is generally dealt with at an organizational level. The aim is to identify the error and seek to correct the reason for it's occurrence (e.g., system errors).
Patient/Client	An individual who requires care (and can include or his/her substitute decision maker).
Professional Relationships	Relationship that a healthcare professional engages in with peer and colleagues in order to carry out his/her professional duties.
Regulated Health Professions Act (RHPA)	Legislation passed in 1991 that sets out the general purpose of the regulatory model for health professionals in Ontario. It identifies the 14 controlled acts that are potentially harmful if performed by unqualified persons and sets out the list of which professions will be self governed under the Act.
Relevant	Having significant and demonstrable bearing.
Respiratory Therapist (RT)/ Registered Respiratory Therapist (RRT)	Refers to Graduate (GRT) and Registered Respiratory Therapists (RRT) who have completed an approved course of study and successfully passed the Canadian Board of Respiratory Care (CBRC) examination.
Respiratory Therapy Act (RTA)	Legislation passed in 1991 which outlines, among other things, the scope of practice of the profession of Respiratory Therapy in Ontario and the controlled act that are authorized to RTs.
Substitute Decision Maker (SDM)	Sometimes required to assist with decision-making for a patient/client in hospital who is considered mentally incapable to make care or treatment decisions. The <i>Health Care Consent Act</i> contains a guide to identifying who the legally authorized SDM is, based on hierarchy of people. The highest-ranking person on the hierarchy who is willing and able to make decisions regarding healthcare for the patient/client becomes the SDM. (HCCA, 1996)
Surge response strategies	Utilized to ensure that those most likely to benefit from care will be able to receive it. Examples to strategies are adherence to the triage principles, patient/client and staff reallocation and alterations in standards of care.
Therapeutic Relationship	Relationship that a healthcare professional engages in with patient/client as well as their family members in order to carry out his/her professional duties.

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College of Respiratory Therapists of Ontario
Ordre des thérapeutes respiratoires de l'Ontario

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This practice guideline will be updated as new evidence emerges or as practice evolves. Comments on this practice guideline are welcome and should be addressed to:

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